SERFF Tracking Number:	*QUAC-127282120*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49202*
Company Tracking Number:			
TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQChoice*		
Project Name/Number:	*/*		

Filing at a Glance

Company: QCA Health Plan, Inc.

Product Name: IQChoice	SERFF Tr Num: QUAC-127282120	State: Arkansas
TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)	SERFF Status: Closed-Approved-Closed	State Tr Num: 49202
Sub-TOI: HOrg02I.005B Individual - Point-of-Service (POS)	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Jim Couch	Disposition Date: 07/08/2011
	Date Submitted: 06/30/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 07/08/2011
	State Status Changed: 07/08/2011
Deemer Date:	Created By: Jim Couch
Submitted By: Jim Couch	Corresponding Filing Tracking Number:

PPACA: Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

This is the amendment to the IQChoice individual product Certificates of Coverage to add the PPACA requirements for grandfathered policies issued prior to April 1, 2010.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*QUAC-127282120*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49202*
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TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQChoice*		
Project Name/Number:	*/*		

Jim Couch, VP of Compliance
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
jim.couch@qualchoice.com
501-228-7111 [Phone] 5118 [Ext]
501-707-6729 [FAX]

Filing Company Information

QCA Health Plan, Inc.	CoCode: 95448	State of Domicile: Arkansas
12615 Chenal Parkway, Suite 300	Group Code:	Company Type: Health Maintenance Organization
Little Rock, AR 72211	Group Name:	State ID Number:
(501) 228-7111 ext. [Phone]	FEIN Number: 71-0794605	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	Three (3) forms --- the amendment and 2 separate benefit summaries.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
QCA Health Plan, Inc.	$0.00	06/30/2011	

SERFF Tracking Number:	*QUAC-127282120*	*State:*	*Arkansas*
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Product Name:	*IQChoice*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/08/2011	07/08/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
IQChoice PPACA Amendment	Note To Reviewer	Jim Couch	06/21/2011	06/30/2011
Filing fee	Reviewer Note	Rosalind Minor	07/08/2011	
Check Attached	Reviewer Note	Rosalind Minor	07/08/2011	

SERFF Tracking Number:	*QUAC-127282120*	*State:*	*Arkansas*
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Product Name:	*IQChoice*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 07/08/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*QUAC-127282120*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49202*
Company Tracking Number:			
TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQChoice*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Cover Page IQChoice Benefit Summary Grandfathered Benefit Plans	Approved-Closed	Yes
Form	IQChoice Benefit Summary HDHP	Approved-Closed	Yes
Form	Cover Page IQChoice Benefits Summary Point of Service	Approved-Closed	Yes
Form	IQChoice Benefit Summary Point of Service	Approved-Closed	Yes

SERFF Tracking Number:	*QUAC-127282120*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49202*
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Product Name:	*IQChoice*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Jim Couch on 06/21/2011 07:37 PM

Last Edited By:

Rosalind Minor

Submitted On:

07/08/2011 03:04 PM

Subject:

IQChoice PPACA Amendment

Comments:

This amendment and the appropriate benefit summary will be mailed to each IQChoice member with a policy with an effective date prior to 4/1/2010. All members with an effective date of 4/1/2010 or later, that is, non-grandfathered plans, have received a previously filed and approved full certificate that is PPACA compliant. This amendment will apply only to grandfathered policies.

SERFF Tracking Number:	*QUAC-127282120*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49202*
Company Tracking Number:			
TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQChoice*		
Project Name/Number:	*/*		

Reviewer Note

Created By:

Rosalind Minor on 07/08/2011 03:03 PM

Last Edited By:

Rosalind Minor

Submitted On:

07/08/2011 03:04 PM

Subject:

Filing fee

Comments:

Check 009339 for $100.00 is attached.

SERFF Tracking Number:	*QUAC-127282120*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49202*
Company Tracking Number:			
TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQChoice*		
Project Name/Number:	*/*		

Reviewer Note

Created By:

Rosalind Minor on 07/08/2011 02:18 PM

Last Edited By:

Rosalind Minor

Submitted On:

07/08/2011 03:04 PM

Subject:

Check Attached

Comments:

Check #009337 in the amount of $150.00 is attached.

QualChoice of Arkansas, Inc. **009339**

AID001 ARKANSAS INSURANCE DEPARTMENT 00000000000009013 7/8/2011

REFERENCE	INVOICE NUMBER	INV DATE	INVOICE AMOUNT	ADJUSTMENT	DISCOUNT	WRITE OFF	NET AMOUNT PAID
00000000000011478	7/8	7/8/2011	$100.00	$100.00	$0.00	$0.00	$100.00
			$100.00	$100.00	$0.00	$0.00	$100.00

addt'l File IQ PPACA GF Ammend

BORDER CONTAINS MICROPRINTING - PANTOGRAPH IS RED/ORANGE/YELLOW/GREEN/BLUE - SEE REVERSE SIDE FOR FULL DISCLOSURE.

QualChoice of Arkansas, Inc.
12615 Chenal Parkway
Suite 300
Little Rock, AR 72211
(501) 228-7111

Arvest Bank
81-87-829

009339

DATE 7/8/2011

AMOUNT $100.00

PAY ONLY 100 00 CENTS (One Zero Zero)

PAY One Hundred Dollars And 00 Cents

TO THE ORDER OF ARKANSAS INSURANCE DEPARTMENT

Michael E. Stock

⑈009339⑈ ⑆082900872⑆ 0011795951⑈

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QualChoice of Arkansas, Inc.
12615 Chenal Parkway
Suite 300
Little Rock, AR 72211
(501) 228-7111

Arvest Bank
81-87-829

009337

DATE 7/2/2011

AMOUNT $150.00

PAY ONLY 150 00 CENTS
One Five Zero

PAY One Hundred Fifty Dollars And 00 Cents

TO THE ORDER OF ARKANSAS INSURANCE DEPARTMENT

⑈009337⑈ ⑆082900872⑆ 00117959516⑈

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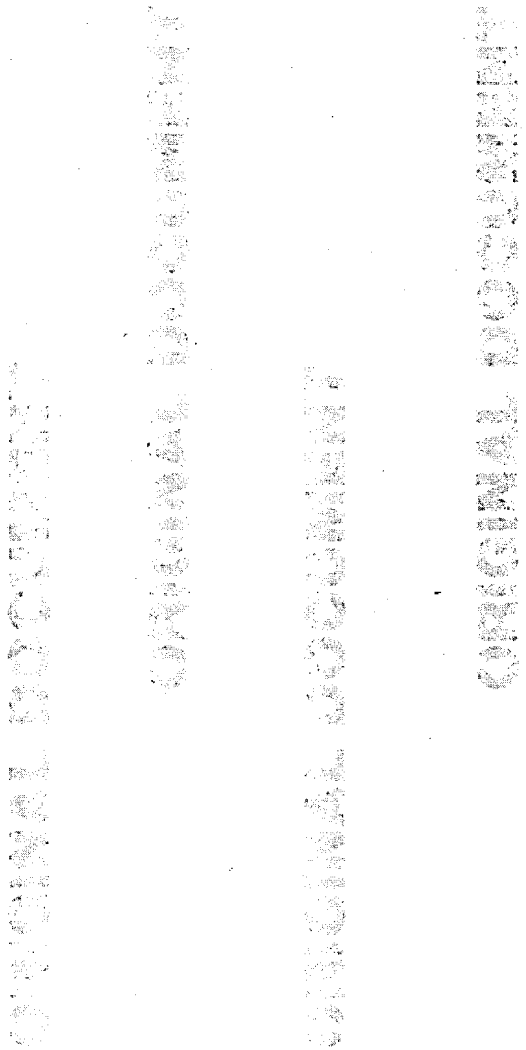

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Product Name:	*IQChoice*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: QC_Indiv_Prod_1 (6-08)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/08/2011	PPACA Amendment to QC_Indiv_Prod_1 (6-08) (1-11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Amendment	Initial			IQChoice PPACA Amendment Jan 2011.pdf
Approved-Closed 07/08/2011	QC HDHPIQ GF (6-08)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Cover Page IQChoice Benefit Summary Grandfathered Benefit Plans	Initial			Cover Page to Form QC HDHPIQ GF (6-08).pdf
Approved-Closed 07/08/2011	QC HDHPIQ GF (6-08)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	IQChoice Benefit Summary HDHP	Initial			Form # QC HDHPIQ GF (6-08) Benefits Summary.pdf
Approved-Closed 07/08/2011	QC POSIQ GF (6-08)	Policy/Contract/Fraternal	Cover Page IQChoice Benefits Summary Point of	Initial			Cover Page to Form QC POSIQ GF (6-

SERFF Tracking Number:	*QUAC-127282120*	*State:*	*Arkansas*
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Product Name:	*IQChoice*		
Project Name/Number:	*/*		

		Certificate: Amendment, Insert Page, Endorsement or Rider	Service			08).pdf
Approved-Closed 07/08/2011	QC POSIQ GF (6-08)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	IQChoice Benefit Summary Point of Service	Initial		Form # QC POSIQ GF (6-08).pdf

AMENDMENT

The QCA Health Plan, Inc. (QualChoice) Certificate of Coverage identified as QC_Indiv_Prod_1 (6-08) approved by the Arkansas Department of Insurance on June 9, 2008 is hereby amended effective January 1, 2011 as follows:

WHEREAS, the Patient Protection and Affordable Care Act (PPACA) requires certain amendments to grandfathered individual health plans; and

THEREFORE, QCA Health Plan, Inc. (hereinafter referred to as "QualChoice") is making the following amendments to the policy:

1. The "**Benefits" section of the "Outline of Coverage"** shall be amended as follows:

   a. "Maximum Benefits" definition shall be deleted in its entirety.

   b. "Age Limitations" shall be amended to read as follows:

      Age Limitations: Dependent children are covered to age 26. Upon reaching age 26, you are responsible for changes in coverage status (from individual to family or from family to individual coverage).

   c. "Special Limitations" shall be amended to read as follows:

      Special Limitations:

      Durable Medical Equipment: A maximum payment of $5,000 per Calendar Year per Enrollee. Please see the Benefits Summary for Cost Sharing Amount.

      Ambulance: See the Benefit Summary.

      Home Health Services: A maximum of 40 visits per Calendar Year per Enrollee. Please see the Benefits Summary for Cost Sharing Amount.

      Physical, Occupational, Speech Therapy, Chiropractic & Audiology Care: A maximum of a total combined 45 visits per Calendar Year per Enrollee. Please see the Benefits Summary for Cost Sharing Amount

2. The "**Benefits and Services Are *Not* Included" section of the "Outline of Coverage"** shall be amended as follows:

   a. "**Pre-existing Condition Exclusion Period**" shall be deleted in its entirety and replaced with the following:

      - **Pre-existing Condition Exclusion Period:** Except for a Child under the age of 19, treatment of Pre-existing Conditions or diseases are not covered until this Policy has been in effect continuously for twelve (12) months. Refer to Section 11 below for a definition of a "Pre-existing Condition". ***There is no credit given toward the Pre-existing Condition exclusion for prior health insurance, unless covered by a Creditable Coverage Rider***.

   b. The reference to coverage for "Psychiatric Conditions" and substance abuse services shall be deleted in its entirety and replaced with the following:

      - Psychiatric conditions and substance abuse services, unless covered by a Mental Health and Substance Abuse Rider.

3. Section 1.1 ("Who Is QualChoice") shall be amended to reflect the correct address of QualChoice:

   12615 Chenal Parkway, Suite 300, Little Rock, Arkansas 72211

4. Section 2.3 ("Provider Network") shall be amended to reflect the correct website address:

   www.qualchoice.com

5. Section 3.2's title "**Ambulance Services – Emergency Only"** shall be replaced with "**Ambulance Services – Transportation"**.

6. Section 3.20 ("Newborn Care in a Non-Participating Hospital") shall be deleted in its entirety and replaced with the following:

   3.20 Newborn Care in a Non-Participating Hospital
   If a child *who is eligible to be an Enrollee* is born in an Out-of-Network Hospital, the child's coverage for Out-of-Network Services in the first 90 days is limited to the Maximum Allowable Payment. If a child who is eligible to be an Enrollee is born in an Out-of-Network Hospital because the Policy Holder's spouse has other health benefit coverage, or if such child is an adopted child born in an Out-of-Network Hospital, nursery charges are covered up to the Maximum Allowable Payment.

7. The first paragraph of Section 3.21(2) ("Outpatient Surgery") shall be deleted in its entirety and replaced with the following:

   2. **Outpatient Surgery:** Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient hospital setting when performed or prescribed by a physician. Covered Services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service. If an Out-of-Network Facility or ambulatory surgery center not contracted with QualChoice is used, payment will be limited to the Maximum Allowable Payment for the service.

   The second paragraph and chart in Section 3.21(2) do not change.

8. Section 4.1(96) ("Exclusions From Coverage" – "Pre-existing Conditions") shall be shall be deleted in its entirety and replaced with the following:

   96. **Pre-existing Conditions:** Benefits for the treatment of a Pre-existing Condition are excluded until the Enrollee has had continuous coverage under this Policy for 12 months. This exclusion of coverage for a Pre-existing Condition does not apply to a Child under the age of 19. In the event, the 12-month Pre-existing Condition period has not expired once a Child reaches the age of 19, this Pre-existing Condition exclusion shall apply to that Child from the time s/he turns 19 until the 12-month Pre-existing Condition period expires.

9. Section 4.1(131) ("Exclusions From Coverage" – "Vision Correction") shall be shall be deleted in its entirety and replaced with the following:

   131. **Vision Correction:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), Laser Assisted Insitu Keratomileusis (LASIK), eyeglass, and contact lenses, except the initial acquisition of one pair within the twelve months following cataract surgery up to a maximum of $200.00 (for frames and lenses), are not covered.

10. Section 4.2(12) ("Limitations to Benefits" – "Transplant Services") shall be deleted in its entirety and replaced with the following:

12. **Transplant Services:** Transplant services are subject to the following benefit maximums:

A. Coverage for procurement (per transplant) is limited to the amount reflected in your Benefits Summary.

B. Lifetime maximum organ transplant coverage is limited to the amount reflected in your Benefits Summary.

C. We will not cover the transportation and/or lodging costs of the transplant donor, or individuals traveling with either the donor or the recipient. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs. Transportation costs of the transplant recipient are covered at the sole discretion and evaluation of the QualChoice Care Management Department. Coverage is limited to no more than two (2) transplants per Enrollee per lifetime. We cover re-transplantation, subject to the transplant limit of two (2).

D. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission or in complete remission less than two years. A solid organ transplant of any kind is not covered for an Enrollee that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.

Organ transplants not pre-authorized by QualChoice Care Management Department are not covered.

11. Paragraphs (2) and (3) of Section 5.3 ("Who is Eligible for Coverage and When Does Coverage Begin") shall be deleted in their entirety and replaced with the following:

2. Your Child until s/he becomes twenty-six (26) years of age. "Child" means your natural child, legally adopted child, child for whom you are the legal guardian, or stepchild, including a child for whom you are the adoptive parent during the waiting period prior to completing the adoption

3. Your incapacitated Child (as defined above) may be an eligible dependent. The incapacitated Child must be twenty-six (26) years of age or older and totally disabled due to continuous developmental or physical incapacity. The incapacitated Child must be primarily dependent on you for financial support and you must declare the incapacitated Child as a dependent on your federal income tax returns. The disability leading to mental or physical incapacity must have occurred before the Child reached age twenty-six (26) and while covered under this Policy or other group medical insurance coverage. The Social Security Administration or a physician must medically certify the disability. In addition to this medical certification, we have the unilateral right to determine whether a Child is, and continues to qualify as an incapacitated Child. At any time, we may request a declaration of disability (or like document) supporting such dependent's incapacity and dependency. You must notify us if the incapacity or dependency is removed or terminated. Newly eligible Enrollees may enroll an incapacitated Child provided the disability commenced before the limiting age and a health

benefit plan continuously covered the Child as your dependent since before the limiting age. Our determination of eligibility shall be conclusive.

12. Section 6 ("Coordination of Benefits") shall be deleted in its entirety and replaced with the following:

6. COORDINATION OF BENEFITS

You and your family members may have coverage under more than one health policy. This Policy contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. There is no COB for prescription drugs supplied at the retail pharmacy. COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

6.1. How COB Works

The order of benefit determination rules govern the order in which each health policy will pay a Claim for benefits. The health policy that pays first is called the primary policy. The primary policy must pay benefits in accordance with its policy terms without regard to the possibility that another health policy may cover some expenses. The plan that pays after the primary policy is the secondary policy. The secondary policy may reduce the benefits it pays so that payments from all health policies do not exceed 100% of the COB Allowable Expense (described in Section 6.4 below).

6.2. Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary policy coverage:

1. If a health policy does not have a COB provision, that policy is primary.

2. The health policy covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health policy that covers the person as a dependent is secondary.

3. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one health policy the order of benefits is determined as follows:

   A. For a child whose parents are married or are living together, whether or not they have ever been married:

   (1) The health policy of the parent whose birthday falls earlier in the Calendar Year is primary; or

   (2) If both parents have the same birthday, the health policy that has covered the parent the longest is primary.

   B. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(1) The plan of the parent who a court has established as being responsible for the child's health care expenses or health care coverage is primary (we must be informed of this requirement and documentation may be required);

(2) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage , the provisions of Subparagraph A above determines the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subparagraph A above determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) Plan of the custodial parent;

(b) Plan of the custodial parent's new spouse (if remarried);

(c) Plan of the non-custodial parent; and then

(d) Plan of the new spouse of the non-custodial parent (if remarried).

C. For a dependent child covered under more than one health policy of individuals who are the parents of the child, the provisions of Subparagraph A or B above determine the order of benefits as if those individuals were the parents of the child.

4. The health policy that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is primary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another health policy, the health policy covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health policy does not have this rule, and as a result, the health policy or policies do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

6. The health policy that covered the person as an employee, member, policyholder, subscriber or retiree longer is primary and the health policy that covered the person the shorter period of time is secondary.

7. If the preceding rules do not determine the order of benefits, the COB Allowable Expense shall be shared equally between the health policies or policies. In addition, this Policy will not pay more than it would have paid had it been primary.

6.3. Allowable Expense

For the purposes of this Section 6, "Allowable Expense" is a health care expense (including Deductible, Coinsurance or Co-payments) covered in full or in part by any health care plan or policy covering the Enrollee. This means an expense or service not covered by any plan or policy covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans or policies cover you and compute their benefit payments based on that plan's maximum allowable charge, any amount in excess of the Allowable Expense of the primary payor for a specified benefit is not an Allowable Expense.

If two (2) or more plans or policies cover you and provide benefits or services based on negotiated fees, any amount in excess of the negotiated fees of the primary payor is not an Allowable Expense.

If you are covered under multiple plans or policies and the Allowable Expense is determined by more than one method, the primary policy's payment arrangement shall be the Allowable Expense for all plans or policies.

6.4. Reduction of Benefits

When this Policy is secondary, we will reduce our benefits so that the total benefits paid or provided by all plan or policies are not more than one hundred percent (100%) of the total Allowable Expense of the primary policy.

A. In determining the amount to be paid for any Claim, QualChoice will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary policy. QualChoice will then reduce its payment by the amount so that, when combined with the amount paid by the primary policy, the total Benefits paid or provided by all health policy or policies for the Claim do not exceed the total Allowable Expense of the primary policy for that Claim.

B. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other health care coverage.

C. If an Enrollee is enrolled in two or more closed panel plans (that is, a plan or policy that provides benefits primarily through a panel of contracted health care providers and excludes coverage for services provided by other health care providers) and if, for any reason, including the provision of service by an Out-of Network Provider, benefits are not payable by one closed panel plan, COB shall not apply between that closed panel plan and other closed panel plans.

6.5. Enforcement of Provisions

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Plan and other health policy or policies. For the purposes of COB administration, QualChoice will get the facts it needs

from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the Plan and other health policy or policies covering the person claiming benefits. QualChoice is not required to tell, or get the consent of, any person, including the Enrollee, to do this. You must give QualChoice any facts we needs to apply those rules and determine Benefits payable. If you fail to provide this information, we may delay Benefit payments.

6.6. Facility of Payment

A payment made under another health policy may include an amount that should have been paid under this Plan. If it does, QualChoice may pay that amount to the other plan or policy that made that payment. That amount will then be treated as though it were a benefit paid by QualChoice under this Certificate. QualChoice will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.7. Right of Recovery

If we pay more for Covered Services than this provision allows, we have the right to recover the excess payment. You agree to do whatever is necessary to secure our right to recover excess payments.

6.8. Hospitalization When Coverage Begins

Consistent with applicable law, if an eligible Enrollee is inpatient in a hospital on the effective date of this Certificate and immediately prior to such effective date was covered by another group health policy that provides coverage for hospital or medical services or expenses, coverage for benefits under that other policy, contract, or certificate will continue and it will be the primary policy for those services and expenses associated with that hospital admission. As the primary policy, that group health policy will be responsible for those services and expenses until the end of that hospital admission or until the expiration of any applicable extension of benefits provided under such group health policy, whichever occurs first.

13. Section 7.1 ("Initial Communication and Resolution of a Problem or Dispute") shall be deleted in its entirety and replaced with the following:

7.1. Initial Communication and Resolution of a Problem or Dispute

We welcome and encourage (but do not require) discussion of any inquiry, complaint or dispute concerning interpretation of the provisions of this Policy. A Customer Service representative will make every effort to resolve the issue. If we are unable to resolve the issue to the satisfaction of the Enrollee, the Enrollee has the right to request an Internal Review.

A. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "appeal" as described in Section 7.3 below. An "appeal" must be initiated and conducted as described in Section 7.3 below.

B. **Oral Complaints:** An Enrollee having a complaint regarding anything about us may contact a Customer Service Representative at 501-228-7111 or 1-800-235-7111 to assist in resolving the matter informally. The Enrollee may submit a written complaint if not satisfied with the resolution. An Enrollee is not required to make an oral complaint prior to submitting a written complaint.

C. **Written Complaints:** The Enrollee may submit a written complaint to us at the following address:

QualChoice
Attention: Appeals and Grievance Coordinator
P. O. Box 25610
Little Rock, Arkansas 72221

D. **Complaint Resolution.** We will acknowledge receipt of a written complaint within 5 working days. We will investigate the complaint and send the Enrollee a response with resolution. If we are unable to resolve the written complaint within 30 calendar days due to circumstances beyond our control, we will provide notice of the reason for the delay before the 30th calendar day.

14. Section 7.2(5) ("Administrative Issues") shall be deleted in its entirety and replaced with the following:

5. **Administrative Issues**: We consider issues such as those regarding eligibility, coverage, level of coverage, rescission of coverage (that is, cancellation or discontinuance of coverage retroactively (unless due to lack of timely premium payment)), and adherence to prescribed procedures as Administrative Issues.

15. Section 7.3 ("Appeal Process") shall be deleted in its entirety and replaced with the following:

7.3 Appeal Process

1. **Initiating a Pre-Service, Concurrent Care, or Post-Service Internal Appeal:** The Enrollee (or the Enrollee's healthcare provider with regard to a Pre-Service Request, Concurrent Care Request or Urgent Care Request) has 180 calendar days from the date of receipt of the initial determination was made to file a formal written appeal, under this Section 7. To initiate an appeal, an Enrollee (or the Enrollee's healthcare provider) must write to our complaint and appeals coordinator at the following address:

Appeals and Grievance Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

This appeal may also be faxed to:

Appeals and Grievance Coordinator
QualChoice
Fax #: 501-228-9413

2. **Appeal of Pre-Service Request and Concurrent Care Request**

A. **Internal Appeal of Administrative Issues.** After receipt of the written appeal, the Internal Appeal Reviewer will conduct an investigation of the appeal. The Internal Appeal Committee meeting at our office will hear an Internal Appeal of an Administrative Issue. The Enrollee and/or the

treating healthcare provider have the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Internal Appeal Committee's questions. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

B. **Internal Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Internal Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Internal Appeal to a medical director for review and we will notify the Enrollee of a decision within fifteen (15) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

C. **Expedited Appeals**. A request for an expedited appeal for a Pre-Service Request or Concurrent Care Request will be treated as an appeal of an Urgent Care Request as described in Section 7.3(4) below subject to the request meeting the criteria for an Urgent Care Request.

3. **Appeal of Post-Service Claims**

A. **Internal Appeal of Administrative Issues.** After receipt of the written appeal, the Internal Appeal Reviewer will conduct an investigation of the appeal. The Internal Appeal Committee meeting at our office will hear an Internal Appeal of an Administrative Issue. The Enrollee has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Internal Appeal Committee's questions. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

B. **Internal Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Internal Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Internal Appeal to a medical director for review and we will notify the Enrollee of a decision within thirty (30) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

C. **No Expedited Appeals**. There are no expedited appeals for Post-Service Claims.

4. **Appeal of Urgent Care Request**

A. **Initiating an Internal Appeal.** If the Enrollee requests an expedited review and a health care professional with knowledge of the Enrollee's medical condition certifies the determination as a general pre-service

request that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function, the Enrollee or their health care professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413.

An expedited appeal may be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation.

B. **Internal Appeal.** An appeal of an Urgent Care Request will be handled by us as a Medical Issue. A medical director will make the determination on review at both levels of appeal in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator initially receives the request for review.

16. Section 7.4(2) ("Right to Information of Enrollee") shall be modified to add the following paragraph:

In addition, we will provide the Enrollee, free of charge, with any new or additional rationale and/or evidence we consider, rely on, or is generated in connection with the appeal. We will provide this rationale and/or evidence as soon as possible and sufficiently in advance to allow the Enrollee a reasonable opportunity to respond prior to the date of a determination on the appeal being made by us.

17. Section 7.8 ("External Medical Review") shall be deleted in its entirety and replaced with the following:

7.8 External Medical Review

After you have exhausted your Internal Appeal rights with QualChoice and QualChoice has made its final determination with regard to your appeal, a voluntary external review process may be available to you. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Request, please contact QualChoice's Appeals and Grievance Coordinator at 501-228-7111 or 1-800-235-7111.

The external review process is only available if the determination you appealed was based on whether the healthcare service was Medically Necessary or experimental/investigational and the adverse determination by QualChoice will cause you or your Dependent to have medical expenses in excess of $500.00.

An external review is not available for such things as a denial based on an express exclusion in this Policy, an express limitation in this Policy, dollar limits under this Policy, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made within sixty (60) days of your or your Dependent's receipt of QualChoice's denial and in writing to:

Appeals and Grievance Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization selected by QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee to file the request for the external review which would be refunded to you in the event QualChoice's determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization for consideration. You or your Dependent will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on you, your Dependents, and QualChoice, unless other remedies are available under applicable state or federal law.

You may contact the Arkansas Insurance Commissioner for assistance at any time. The mailing address is: Arkansas Insurance Department, Attn: External Review Assistance, 1200 West Third Street, Little Rock, AR 72201. Their telephone number is 501-371-2640 or toll free 800-852-5494. Their email address is insurance.consumers@arkansas.gov.

18. The following shall be added to Section 9 ("Pre-Existing Conditions"):

This exclusion of coverage for a Pre-existing Condition does not apply to a Child under the age of 19. In the event the 12-month Pre-existing period has not expired once a Child reaches the age of 19, this Pre-existing Condition exclusion shall apply to that Child from the time s/he turns 19 until the 12-month Pre-existing period expires.

19. Section 10.16 ("Rescission") shall be deleted in its entirety and replaced with the following:

Subject to the time limits set out in Section 10.19, we may rescind coverage under this Policy if an Enrollee performs an act, practice, or omission that constitutes fraud, or the Enrollee makes an intentional misrepresentation of material fact. In the event we rescind coverage, we have the right to demand that you pay back all the Benefits we paid to you, your Dependents, or on your or your Dependent's behalf during the period of time that you or your Dependent should not have been covered under this Policy. In these circumstances, we may also obtain refunds from providers that rendered services to you or your Dependent when coverage should not have been provided, in which case that provider may seek to obtain reimbursement from you for the amount obtained by us from that provider.

20. The following will be added to Section 11.29 (definition of "Pre-existing Condition"):

Notwithstanding the definition above, with respect ONLY to an Enrollee who is under nineteen (19) years of age, "Pre-existing Condition" means a condition that was present before the effective date of coverage, or if coverage is denied, the date of the denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day.

A Pre-existing Condition can be identified through information relating to health status before the Enrollee's effective date of coverage or if coverage is denied, the date of the denial, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the Enrollee, or review of medical records relating to the pre-enrollment period.

All other terms and conditions of the Policy shall remain in full force and effect.

Michael E. Stock, President & CEO
QCA Health Plan, Inc. ("QualChoice")
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

ARKANSAS CONSUMER INFORMATION NOTICE

If you need additional information about this Policy, please contact us at:

QCA Health Plan, Inc.

12615 Chenal Parkway, Suite 300

Little Rock, AR 72211

(501) 228-7111

If QualChoice is unable to respond to your questions, you should contact:

Arkansas Insurance Department

Consumer Services Department

1200 West Third Street

Little Rock, AR 72201

(501) 371-2640 or (800) 852-5494

This health insurance issuer believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to QualChoice at 1-800-235-7111 or 501-228-7111. If your plan is an ERISA plan, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or *www.dol.gov/ebsa/healthreform.* This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. If your plan is a governmental plan, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

This benefit summary is part of the Certificate of Coverage, Form QC_Indiv_Prod_1 (6-08) and the amendment to it, Form PPACA Amendment to QC_Indiv_Prod_1 (6-08) (1-11), (together the "Certificate of Coverage") and subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon soley to determine coverage. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Certificate of Coverage is different than this benefit summary, the Certificate of Coverage prevails.

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com.

All benefit payments are based on the QualChoice Maximum Allowable Payment. Use of an Out-of-Network Provider may result in you being balance billed and higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Payment do not count toward annual Deductible or Coinsurance limits. See the "Member Financial Responsibility Comparison" section in the Certificate of Coverage.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
~~**Lifetime Benefit Maximum**~~	~~$5,000,000~~	
Annual Deductible ▪ Family deductible is not considered satisfied until the entire family deductible amount is satisfied ▪ The annual Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a Calendar Year will NOT carry over to the next Calendar Year	Individual: **[$2,500-$5,000]** Family: **[$5,000-$10,000]**	
Annual Out-of-Pocket Limit ▪ Applicable Coinsurance will apply until the family Out-of-Pocket Limit is satisfied ▪ Benefits will be paid at 100% of the Maximum Allowable Payment once the family annual Coinsurance Limit is satisfied ▪ Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits. ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis ▪ Annual Coinsurance Limit does not include Deductible amounts	Individual: **[$0-$2,000]** Family: **[$0-$4,000]**	Individual: **[$5,000-$40,000]** Family: **[$10,000-$80,000]**
Coinsurance	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Preventive Care Services:		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Routine vision exam (limit one every 24 months)	Paid in full	Not Covered
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Certificate of Coverage.*	Deductible applies after $500 annual Preventive Services Maximum has been met	
Well baby care, birth - to age 2 Well child care, ages 2-18 Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	Deductible applies after $500 annual Preventive Services Maximum has been met	**[0%-100%]** after Deductible

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually ▪ Flexible sigmoidoscopy once every 5 years, OR ▪ Double contrast barium enema, OR ▪ Preventive colonoscopy age 50 and older, once every 10 years	Deductible applies after $500 annual Preventive Services Maximum has been met	**[0%-100%]** after Deductible
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine injectible medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Other Professional services ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures, such as chemotherapy, radiation therapy and infusion therapy ▪ Complex injectible medications which include: All specialty medications such as, enbrel, humira, IV medications and high potency antibiotics ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Inpatient Care - Room and Board		
▪ Inpatient care - room and board ▪ Rehabilitation Care and Skilled Nursing ([**0 to 365**] day limit per Calendar Year for each) *Note: ~~Out-of-Network newborn coverage is limited to $2,000 per newborn for all services. Includes first 90 days after birth.~~*	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice (limited to a lifetime maximum of **[0 to 365]** days) ▪ Outpatient Surgical Services	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
▪ Home Health Services ([**0 to 400**] visits per Calendar Year) *Note: ~~Out-of-Network outpatient surgery is limited to $500 for all services. You will be responsible for all other charges.~~*	**[0%-100%]** after Deductible	
Emergency Room Services		
▪ Emergency Room, Urgent Care or ER Observation Services	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per Calendar Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	[0%-100%] after Deductible	[0%-100%] after Deductible
Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care ▪ Audiology Care	**[0%-100%]** after Deductible	Not Covered
▪ Cardiac Rehabilitation ([**0 to 300**] visits per Calendar Year) *Note: Therapy and chiropractic services are limited to a combined maximum of **[0 to 300]** visits per Calendar Year. This does not include Cardiac Rehabilitation.*	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services	**[Not Covered]** or **[[0%-100%] after Deductible]**	**[Not Covered]** or **[[0%-100%] after Deductible]**
Facility Services *Note: ~~Out-of-Network newborn coverage is limited to $2,000 per Enrollee for all services. Includes first 90 days after birth.~~*	**[Not Covered]** or **[[0%-100%] after Deductible]**	**[Not Covered]** or **[[0%-100%] after Deductible]**
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	**[0%-100%]** after Deductible	Not Covered
Mental Health and Substance Abuse		
Professional Services (Office Visits) Inpatient Hospital Services Professional Services (Inpatient Facility)	**[Not Covered]** or **[[0%-100%] after Deductible]**	**[Not Covered]** or **[[0%-100%] after Deductible]**
Allergy Services		
Allergy Testing and shots	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ **[$0-$200,000]** maximum benefit per Calendar Year	**[0%-100%]** after Deductible	Not Covered
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately ▪ Provided in connection with home infusion therapy	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
▪ Provided in connection with Durable Medical Equipment	**[0%-100%]** after Deductible	Not Covered
Prosthetics and Orthotics ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.*	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Reconstructive Surgery ▪ Breast reconstruction (48 hour minimum hospital stay) ▪ Restoration due to acute trauma, infection or cancer	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Transplant Services ▪ Lifetime maximum of two transplants or **[$0-$20,000,000]**	**[0%-100%]** after Deductible	Not Covered
Diabetes Management Services ▪ Supplies and equipment ▪ Diabetic Education (**[0 to 100]** training per lifetime)	**[0%-100%]** after Deductible	Not Covered
Dental Care ▪ Accidental injury to sound and natural teeth ▪ **[$0-$100,000]** maximum benefit per accident	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid **[$0-$5,000]** per year	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Genetic Testing *Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	No benefits if not pre-authorized **[0%-100%]** after Deductible	No benefits if not pre-authorized **[0%-100%]** after Deductible

NOTE: This High Deductible Health Plan is qualified for use with a Health Savings Account.

This health insurance issuer believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to QualChoice at 1-800-235-7111 or 501-228-7111. If your plan is an ERISA plan, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or *www.dol.gov/ebsa/healthreform.* This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. If your plan is a governmental plan, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

This benefit summary is part of the Certificate of Coverage, Form QC_Indiv_Prod_1 (6-08) and the amendment to it, Form PPACA Amendment to QC_Indiv_Prod_1 (6-08) (1-11), (together the "Certificate of Coverage") and subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon soley to determine coverage. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Certificate of Coverage is different than this benefit summary, the Certificate of Coverage prevails.

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com.

All benefit payments are based on the QualChoice Maximum Allowable Payment. Use of an Out-of-Network Provider may result in you being balance billed and higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Payment do not count toward annual Deductible or Coinsurance limits. See the "Member Financial Responsibility Comparison" section in the Certificate of Coverage.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
~~**Lifetime Benefit Maximum**~~	~~$5,000,000~~	
Annual Deductible ▪ Co-payments are not included in the annual Deductible ▪ In-Network and Out-of-Network Deductibles apply separately ▪ Family Deductible is not considered satisfied until at least two (2) separate family members have satisfied their individual Deductibles ▪ The annual Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year	Individual: **[$500-$35,000]** Family: **[$1,000-$70,000]**	Individual: **[$1,000-$70,000]** Family: **[$2,000-$140,000]**
Annual Out-of-Pocket Limit ▪ Applicable Coinsurance will apply until two separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit ▪ Benefit will be paid at 100% of the Maximum Allowable Payment once the family annual Coinsurance limit is satisfied ▪ Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits ▪ Co-payments do not apply toward your Out-of-Pocket Limits. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis	Individual: **[$0-$2,000]** Family: **[$0-$4,000]**	Individual: **[$5,000-$40,000]** Family: **[$10,000-$80,000]**
Coinsurance	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Preventive Care Services:		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Certificate of Coverage.*	Paid in Full	
Routine vision exam (limit one every 24 months)	**[$0-$100]** Co-payment	Not Covered
Well baby care, birth - to age 2	**[$0-$100]** Co-payment	**[0%-100%]** after Deductible
Well child care, ages 2-18	**[$0-$100]** Co-payment	**[0%-100%]** after Deductible
Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	PCP: **[$0-$100]** Co-payment or Specialist: **[$0-$150]** Co-payment	**[0%-100%]** after Deductible

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually	PCP: **[$0-$100]** Co-payment or Specialist: **[$0-$150]** Co-payment	**[0%-100%]** after Deductible
▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy, age 50 and older, once every 10 years	**[0%-100%]** after Deductible	
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine injectible medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	**[$0-$100]** Co-payment	**[0%-100%]** after Deductible
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	**[$0-$150]** Co-payment	**[0%-100%]** after Deductible
The following professional services are subject to Deductible and Coinsurance: ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures - chemotherapy, radiation therapy and infusion therapy ▪ Complex injectible medications which include: All specialty medications such as, enbrel, humira, IV medications and high potency antibiotics ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Inpatient Care - Room and Board		
▪ Inpatient care - room and board (semi-private only) ▪ Rehabilitation Care and Skilled Nursing (**[0 to 365]** day limit per Calendar Year for each) *Note: ~~Out-of-Network newborn coverage is limited to $2,000 per newborn for all services. Includes first 90 days after birth.~~*	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice (limited to a lifetime maximum of **[0 to 365]** days) ▪ Outpatient Surgical Services	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
▪ Home Health Services (**[0 to 400]** visits per Calendar Year)	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Note: ~~Out-of-Network outpatient surgery is limited to $500 for all services. You will be responsible for all other charges.~~		
Emergency Room Services		
▪ Emergency Room or Urgent Care	**[$0-$2,000]** Co-payment	**[$0-$2,000]** Co-payment
▪ ER Observation Services	**[$0-$2,000]** Co-payment	**[$0-$2,000]** Co-payment
Transportation Services		
▪ Ambulance - Ground or Air (**[$0-$10,000]** maximum benefit per Calendar Ye	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Note: Facility to facility ambulance transfer requires pre-authorization.		
Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care	**[0%-100%]** after Deductible	Not Covered
▪ Cardiac Rehabilitation (**[0 to 300]** visits per Calendar Year)	**[$0-$150]** Co-payment	**[0%-100%]** after Deductible
*Note: Therapy and chiropractic services are limited to a combined maximum of **[0 to 300]** visits per Calendar Year. This does not include Cardiac Rehabilitation.*		

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services	**[Not Covered] or [0% to 100% after Deductible]**	**[Not Covered] or [[0%-100%] after Deductible]**
Facility Services *Note: ~~Out-of-Network newborn coverage is limited to $2,000 per Enrollee for all services. Includes first 90 days after birth.~~*	**[Not Covered] or [0% to 100% after Deductible]**	**[Not Covered] or [[0%-100%] after Deductible]**
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	**[0%-100%]** after Deductible	Not Covered
Mental Health and Substance Abuse		
▪ Professional Services (Office visit)	**[Not Covered] or [$50 Co-payment]**	**[Not Covered] or [[0%-100%] after Deductible]**
▪ Inpatient Hospital Services ▪ Professional Services (Inpatient Facility)	**[Not Covered]** or **[[0% to 100%] after Deductible]**	
Allergy Services		
▪ Allergy Testing and Allergy Shots	PCP: **[$0-$100]** Co-payment OR Specialist: **[$0-$150]** Co-payment	**[0%-100%]** after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ **[$0-$5,000]** maximum benefit per Calendar Year	**[0%-100%]** after Deductible	Not Covered
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.	PCP: **[$0-$100]** Co-payment or Specialist: **[$0-$150]** Co-paym	**[0%-100%]** after Deductible
▪ Provided in connection with home infusion therapy	**[0%-100%]** after Deductible	
▪ Provided in connection with Durable Medical Equipment	**[0%-100%]** after Deductible	Not Covered
Prosthetics and Orthotics ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.*	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Reconstructive Surgery ▪ Breast reconstruction (48 hour minimum hospital stay) ▪ Restoration due to acute trauma, infection or cancer	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Transplant Services ▪ Lifetime maximum of two transplants ~~or **[$0-$20,000,000]**~~	**[0%-100%]** after Deductible	Not Covered
Diabetes Management Services ▪ Supplies and equipment ▪ Diabetic Education (**[0 to 100]** training per lifetime)	**[0%-100%]** after Deductible **[$0-$150]** Co-payment	**[0%-100%]** after Deductible **[0%-100%]** after Deductible
Dental Care ▪ Accidental injury to sound and natural teeth ▪ **[$0-$100,000]** maximum benefit per accident	**[$0-$150]** Co-payment and **[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid **[$0-$5,000]** per year	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
Genetic Testing *Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	No benefits if not pre-authorized **[0%-100%]** after Deductible	No benefits if not pre-authorized **[0%-100%]** after Deductible

SERFF Tracking Number:	*QUAC-127282120*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49202*
Company Tracking Number:			
TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQChoice*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/08/2011

Comments:
Please see attached letter.
Attachment:
IQChoice Amendment Flesch Score Letter June 2011.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	07/08/2011
Bypass Reason:	Existing application previously filed and approved will continue to be used.		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	07/08/2011
Bypass Reason:	Not necessary for the filing of this amendment that does not address rates.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	07/08/2011

Comments:
Please see attached.
Attachment:
PPACA Uniform Compliance Summary.pdf

QualChoice®

QualChoice Life and Health Insurance Company, Inc.
QCA Health Plan, Inc.
QualChoice Holdings, Inc.

VIA SERFF

June 30, 2011

Ms. Rosalind Minor
Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: QCA Health Plan, Inc. IQChoice® Amendment to Certificate of Coverage; Form #: PPACA Amendment to QC_Indiv_Prod_1 (6-08)(1-11)

Dear Ms. Minor:

This certifies that the IQChoice® Amendment to Certificate of Coverage, Form #: PPACA Amendment to QC_Indiv_Prod_1 (6-08)(1-11) which adopts the requirements of PPACA does not meet the minimum score of forty (40) on the Flesch reading ease test as specified in Ark. Stat. Ann. § 23-80-206. Although the score is lower than the minimum required, it should be approved in accordance with Ark. Stat. Ann. § 23-80-207 and warranted due to the nature of the policy form and necessary inclusion of medical terminology and language drafted to conform to state and federal law.

Please feel free to contact me at any time should you need additional information or have any questions or comments. Thank you.

Sincerely,

James W. Couch
Vice President of Compliance
jim.couch@qualchoice.com
(501) 219-5118

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PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☑ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
QCA Health Plan, Inc.	95448	QUAC-127282120	QC_Indiv_Prod_1 (6-08)	☐ Yes ☑ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Some policies are grandfathered, while others are not. This amendment will apply to both.			
	Page Number: 1, 2, & 11			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Some policies are grandfathered, while others are not. This amendment will apply to both.			
	Page Number: See Benefits Summaries			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: See Benefit Summaries. No reference to lifetime dollar limits on ess. benefits.			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number: 11			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: See Benefit Summaries that reflect no cost sharing for in-network providers.			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 1 & 3			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Though not required, will apply to both GF and non-GF policies.			
	Page Number: 7 - 11			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no,** please explain.
	Explanation: Current filed and approved policy did not require prior authorization so no change necessary.			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Current filed and approved policy does not require designation of PCP, so no change necessary.			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Current filed and approved policy does not require authorization or referral to OB/GYNs, so no change necessary.			
	Page Number:			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			